City of Long Beach
DEPARTMENT OF HUMAN RESOURCES

RELEASE OF MEDICAL INFORMATION

TO BE COMPLETED BY EMPLOYEE

I hereby authorize the medical staff of the City of Long Beach, Department of Health and Human Services, to obtain and examine any and all medical records in the custody of any physician, clinic, or hospital in connection with my disability referred to in the Certificate of Medical Disability completed by:

Dr. _____ on _____ .
(name) (date)

I further understand and agree that the use of such records will be limited to the verification of the facts and opinions set forth in the above –mentioned certification with respect to my disability.

(PLEASE PRINT OR TYPE)

_____ _____
Employee's Signature **Employee's Name**

_____ _____
Date **Classification**

_____
Department/Bureau/Division

Original : Department of Health and Human Services
cc: Departmental File
Physician File